Issued: 11/98

## Appendix 20 SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

					<del></del>					lov #		
MAIL T	ТО					L	PA/DR			ICN #		
PRIOR AUTHORIZATION UNIT 6406 BRIDGE ROAD					P	RIOR AUT	NSIN MEDIO HORIZATION	N REQUE	STFORM	1. PROCESSING TYPE (MARK ONE)		
SUITE 88 MADISON, WI 53784-0088				A.T.#	(DO NO	T WRITE IN	THIS SP	ACE)	DENTAL - 124			
				P.A. #	1	2716	392		ORTHO - 125			
. R	RECIPIENT'S MEI	DIÇAID I	NUMBER	<del></del>	1				STREET,	, CITY, STATE, ZIP CODE)		
. F	RECIPIENT'S N	IAME (L	AST, FIRS	T, MIDDLE INI	TIAL)							
	name exactly a											
5 DATE OF BIRTH 6. SEX 7. BILLING PROVIDER NO						NO.	7			8 PERFORMING PROVIDER NO. (if different)		
BILLI	NG PROVIDER N	LAME, AD	DRESS, ZIP	CODE						10. PROVIDER TELEPHONE NO.		
	mped, please st											
										11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:		
										- INPATIENT HOSPITAL (POS 1) - OUTPATIENT HOSPITAL (POS 2)		
										- AMBULATORY SURG. CENTER (POS B) - DENTAL OFFICE (POS 3)		
	45	14	146					16.		<u> </u>		
ютн #	13. PROCEDURE CODE	14. QUAN.	15.	DESCRIPTION					EE	Circle periodontal case type if applicable to the service requested     II III IV V		
$\dashv$										Cross out missing teeth		
							-	_		Circle teeth to be extracted		
						·			$\top$			
									$\top$			
$\dashv$										MICHT SLEFT NOV		
-		_	<del>                                     </del>						<del>                                     </del>	-		
		L	1				18 TOTAL		+	Section of the sectio		
n appro	ved prior authoriza	ation does	not guarantee	e payment Prior a	uthorized sen	rices: 1) are s	FEES ubject to the app	licable term	s of			
imbursi Boartmi	ement issued by the ent or its fiscal age Payment will not be	ne Departr int; and 3)	nent; 2) must t are reimbursa	be provided consi able only if and to	stent with a prid the extent the	or authorization provisions of s	on, as approved s. HFS 107.02(3	or modified 3), Wis. Adm	by the iin. Code,	FACIAL		
rolled i	in a Medicaid HMC by the HMO and al	at the tin	ne a prior auth	iorized service is (	provided, reim	bursement wi	ill be allowed on	ly if the sen	ice is not	NUMBER OF X-RAYS		
	,				ndien-11	<del></del> 1	20 0=	REOPM	NG PR	TYPE OF X-RAYS		
13.	RECIPIENT/	JUAK	DIAN SIG	IMIURE (U	puvildi)					se stamp every copy)		
Date	<b>)</b>						Date		· · · · · · · · · · · · · · · · · · ·			
		ME	DICAIL	CONSU	JLTAN	USE	ONLY -	DO	Y TON	WRITE IN THIS SPACE		
OHTL	RIZATION:	_			, .			PROC	EDURE(S	authorized: QUANTITY AUTHORIZED:		
	Ш				l [							
AP	PROVED		GRAN	DATE		EXPIRA	TION DATE	_				
М	ODIFIED	R	EASON					_				
	$\Box$	. –										
_		_										
	DENIED	R	EASON					_				

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## Appendix 20 SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

(continued)

MAIL T	O:				PA/	DRF		ICN #		
EDS PRIOR AUTHORIZATION UNIT						EDICAID DEN		1. PROCESSING TYPE (MARK ONE)		
6406 BRIDGE ROAD PRI SUITE 88 MADISON, WI 53784-0088 A.T.#						TION REQUES E IN THIS SPA		DENTAL - 124		
				1 '			-			
				P.A.#	127	L692		ORTHO - 125		
2 F	ECIPIENT'S MED	HCAID ID	NUMBER				STREET, CI	ITY, STATE, ZIP CODE)		
3. F	RECIPIENTS N	AME (L/	AST, FIRST, MIDDLE INITE	AL)		(	, ,	.,,		
	name exactly a	s it appe 6. SEX	ears on the Medicaid ID car 7. BILLING	PROVIDER NO.				8. PERFORMING PROVIDER NO. (if different)		
	,	M	f							
9. BILLI	NG PROVIDER N	AME, ADI	DRESS, ZIP CODE		<del></del>			10. PROVIDER TELEPHONE NO.		
(If sta	mped, piesse sti	imp every	copy)							
							ŀ			
								11. INDICATE IF THE SERVICE WILL BE PERFORMED IN  - INPATIENT HOSPITAL (POS 1)  - OUTPATIENT HOSPITAL (POS 2)  - AMBULATORY SURG. CENTER (POS 8)		
						1.46		- DENTAL OFFICE (POS 3)		
12. 100TH	13. PROCEDURE CODE	14. QUAN.	15. DES	CRIPTION		16.	EE	7. Circle periodontal case type if applicable to the service requested  1 II III IV V		
							:	Cross out missing teeth  Circle teeth to be extracted  430077		
				·						
							+	CONTROL CONTRO		
								RIGHT ALEFT AND THE PROPERTY AND THE PRO		
								© 1		
					18. TO	TAL ES		Control of the contro		
An anon	wad orior authoriza	ation does	not guarantee payment. Prior aut	thorized services: 1) a	are subject to the	e applicable term	sof	The state of the s		
reimburs Decadm	ement issued by the	ne Departm nt: and 3) :	nent; 2) must be provided consiste are reimbursable only if and to the	ent with a prior authori e extent the provision	zation, as appi s of s. HFS 10	oved or modified ( 7.02(3), Wis. Adm	oythe In. Code,	~		
are met. <del>craollo</del> d	Payment will not be in a Medicaid HMC	e made for o at the tim	services initiated prior to the app le a prior authorized service is pro	roval or after the auth	orization expir	ation date. If the re	ecipient is	NUMBER OF X-RAYS		
covered	by the HMO and a	ll other pro	gram requirements are met.					TYPE OF X-RAYS		
19.	RECIPIENT/	GUARI	DIAN SIGNATURE (Op	tional)	20.			IDER SIGNATURE		
			***			(If stampe	d, please	stamp every copy)		
					Dat	e				
Date	3						IST			
Date						CHECK				
	YOU EN	CLOS						EQUIRING ENCLOSURES		
IAVE			ED?			Periodonta	RVICES RE	g required for any of the following procedu		
AVI (-rays	F <b>YOU EN</b> O for any of pace maintain	the foi ner	ED? Ilowing:			Periodonta	RVICES RE al chartin ontal scali	g required for any of the following proceduing and root planing		
YAVE (-rays	F YOU ENG	the foi ner	ED? Ilowing:			Periodonta Period Full mo	RVICES RE	g required for any of the following proceduing and root planing		
YAVE (-rays S R E	F YOU ENG for any of pace maintain esin window indodentics artials and fix	the foi ner SSC/re ked pro	ED7  Illowing: esin crown sthetics			Periodonta Period Full mo Period Partial	al charting ontal scali outh debric ontal main s (for perio	g required for any of the following proceduing and root planing dement attendance ocase types II, III, IV, and V only)		
C-rays S R E P	for any of pace maintainesin window ndodontics artials and fit urgical expos	the follower SSC/reced pro- sure of	ED7  Illowing: esin crown sthetics unerupted tooth			Periodonta Period Full mo Period Partial	al charting ontal scali outh debric ontal main s (for perio	g required for any of the following proceduing and root planing dement		
Grays S R E P S R	F YOU ENG for any of pace maintain esin window indodentics artials and fix urgical expose emoval of for incheck refer	the foi ner SSC/re ked pro sure of reign bo	ED7  Illowing: esin crown sthetics unerupted tooth ody r any of the followin	RIODONTICS, EI		Periodonta Periodonta Period Full me Period Partial Fixed	al charting ontal scali buth debric ontal main s (for perio prosthodo	g required for any of the following proceduing and root planing dement attendance ocase types II, III, IV, and V only)		
G-rays S R E P S R	for any of pace maintain esin window modoontics artials and fix urgical exposemoval of for the check refersteoplasty/O	the former SSC/reced progure of reign borral for orthogonal	ED7  Illowing: esin crown sthetics unerupted tooth	RIODONTICS, EI		Periodonta Periodonta Period Full me Period Partial Fixed Statement Palata	al charting ontal scali outh debrid ontal main s (for perio prosthodo	g required for any of the following proceduling and root planing dement tenance o case types ii, iii, iV, and V only) intics (abutment teeth)		
G-rays S R E P S R Health	for any of pace maintain eain window modulics and fix urgical exposemoval of for the check refers teoplasty/Ourgical exposemoulectomy	the former SSC/reced progure of reign borral for orthogonal	ED7  Illowing: esin crown  Isthetics unerupted tooth  Index unerupted tooth	RIODONTICS, EI		Periodonta Period Full me Period Partial Fixed Statement Palata	al charting ontal scali outh debrid ontal main s (for perio prosthodo	g required for any of the following proceduling and root planing dement tenance o case types ii, iii, iV, and V only) intics (abutment teeth) ech impediment for: rements - Enclose each of the following:		
Grays SREP SR Realth OSF	for any of pace maintainesin window mododntics artials and figurgical exposemoval of for Check refersteoplasty/Ourgical exposemulectomy withodontics	the follower SSC/recked prosure of reign borral for rithognassure of	ED?  Illowing: esin crown  sthetics unerupted tooth ody r any of the following sthic surgery unerupted tooth	eg:	NDODONT	Periodonta Period Full me Period Partial Fixed  Statement Palata  TMJ surg Secon Docum	al charting ontal scaling on the debric outh debric outh debric outh a main s (for peric prosthodo on speed lift en y required surgical ment non-s	g required for any of the following procedu ing and root planing dement thenance o case types il, ill, IV, and V only) intics (abutment teeth) ech impediment for: rements - Enclose each of the following: opinion surgical treatment		
YAVI (-rays S R E P S R Health	for any of pace maintainesin windown andodontics artials and fix urgical exposemoval of for incheck refersteoplasty/O urgical exposemulectomy orthodontics	the foliater SSC/recked prosure of reign borral for rithognasure of	ED7  Illowing: esin crown  Isthetics unerupted tooth  Index unerupted tooth	g:	NDODONT	Periodonta Period Full me Period Partial Fixed  Statement Palata  TMJ surge Secon Docum Opera	al charting ontal scaling on the debric outh debric outh debric outh a main s (for peric prosthodo on speed lift en y required surgical ment non-s	g required for any of the following proceduling and root planing  dement  tenance o case types il, ill, iV, and V only)  ntics (abutment teeth)  ech Impediment for:  rements - Enclose each of the following:		